DETERMINATION OF INCAPACITY STATUS

Name: _____

Case Number: _____

Application Date: ____/____/____

Return Completed Form to:
Centralized Scanning Unit (CSU)
P.O. Box 181
Concord, NH 03301

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

This authorization expires 12-months from the date this form is signed.

Persons/organizations authorized to use and/or disclose the information: Health Care Provider.

Persons/organizations authorized to receive the information: New Hampshire Department of Health & Human Services (DHHS), including contract staff.

Specific description of information that may be used/disclosed: Information specifying capacities, environments, activities and/or limitations related to your ability to support or care for your children for a period of at least 30 continuous days.

The information will be used/disclosed for the following purposes: Information will be used to determine eligibility for Financial Assistance to Needy Families (FANF) financial or medical assistance.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I further understand that my refusal to sign this authorization may result in denial of my FANF assistance. *I understand that I must have a physician, physician's assistant (PA), advanced practice registered nurse (APRN), or psychologist certify the information on the other side of this form and only a physician, PA, APRN, or psychologist is allowed to sign the other side.* I understand that I may revoke this authorization at any time by notifying DHHS in writing. However, the revocation will not be valid if:

1. DHHS has already taken action based upon this authorization; or
2. This authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Please sign, date, and print your name below.

_____ _____
Signature Date

_____
Printed Name

DEAR PHYSICIAN, PHYSICIAN'S ASSISTANT (PA), ADVANCED PRACTICE REGISTERED NURSE (APRN), OR PSYCHOLOGIST:
YOU ARE RECEIVING THIS FORM BECAUSE YOU ARE THE HEALTHCARE PROVIDER FOR THE INDIVIDUAL IDENTIFIED ON THE BACK OF THIS SHEET.

The individual identified on the back of this sheet is requesting Financial Assistance for Needy Families (FANF) based on his/her incapacity. To qualify for FANF, the individual must be physically or mentally incapacitated to the extent that his/her ability to support or care for his/her children is substantially reduced, and the incapacity is expected to last for a period of 30 continuous days from the application date identified on the back of this sheet, or lasted 30 continuous days in the 90 day period prior to the application date identified on the back of this sheet.

A Physician, PA, APRN, or Psychologist only must certify the information on this form. Please complete the following statements and sign where indicated.

I certify that the individual identified on the back of this sheet (check all that apply):

☐ **IS NOT incapacitated.**

☐ **IS or WAS incapacitated beginning: _____/_____/_____ &**

☐ the incapacity ended _____/_____/_____

☐ the incapacity is expected to last until _____/_____/_____

The diagnosis for this incapacity is _____
Psychiatric diagnosis may be indicated by the current DSM code(s)

My diagnosis is based on:

☐ Examination (____/_____/_____)

☐ Medical Records (____/_____/_____)

☐ Other (specify) _____ (_____/__/__)

Medical treatment I am currently giving this individual: _____

_____

Medical treatment I recommend for this individual: _____

_____

Address:

_____
Printed Name of Physician, PA, APRN, or Psychologist

_____

_____
Specialty

_____

Phone: _____

_____ _____
Signature of Physician, PA, APRN, or Psychologist **Date**

Payment of any separate charge for completing this form is the responsibility of the patient. DHHS will not pay charges solely for the completion of medical forms.

Return to: Centralized Scanning Unit (CSU), P.O. Box 181, Concord, NH 03301